| | | AND HUMAN SERVICES & MEDICAID SERVICES 45 | A 9 | 102/17/20\$ 9125/17 | FORM | : 07/20/2017 APPROVED : 0938-0391 |
|--|--|--|--|--|--|---|
| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | 1 1 | | | (X3) DATE SURVEY COMPLETED | |
| NAME OF | PROVIDER OR SUPPLIER | 44E445 | B, WING | | | 17/2017 |
| | | and the EV | | STREET ADDRESS, CITY, STATE, ZIP CODE 700 WILLIAMS FERRY RD | | |
| DAPTIO | FHEALTH CARE CEN | * CPK | | LENOIR CITY, TN 37771 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION) | ID PREFII TAG | | ULD BE | (X5) COMPLETION DATE |
| K 000 | I INITIAL COMMENT | rs | ΚO | 000 <u>K 291:</u> | | ! |
| | A life safety survey was conducted by the state of Tennessee Department of Health, Division of health licensure and regulation office of health care facilities on 7/17/17. During this life safety survey, Baptist Health Care Center was not found to be in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR Subpart 483.70(a), Life safety from fire, and the related National Fire Protection Association (NFPA) standard 101 - 2012 edition. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by: NFPA 101 Emergency Lighting | | How the corrective act on(s) will be accomplished for those residents found to have been affected by the deficient practice. All emergency lighting in facility was tested for 90 minutes on 7-18-17 and 7-19-17. How the facility will identify other Residents having the potential to be affected by the same deficient practice. | | | |
| SS=F | Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain emergency lighting with battery backup. This deficiency affected 8 of 8 smoke compartments. NFPA 101, 19.7.6 NFPA 101, 7.9.3.1.1(3) The finding includes: Observation and interview with the maintenance director on 7/17/17 at 9:41 AM revealed the emergency lighting with battery backup was not being tested for 90 minutes annually. | | | All residents have the petential affected. On 7-18-17, the Ma Director in-serviced the main staff to ensure they understan safety code for testing emerge lighting for 90 minutes annual. What measure will be put in or systemic changes made at that the deficient practice where the deficient practice where the changes to the Prevental Maintenance Form that is use emergency lighting checks to | intenance tenance d the life ency lly. I place o ensure vill not Director tive d for | : : |
| ABORATORY | DIRECTOR'S OR PROVID | ER/SUPPLIER REPRESENTATIVE'S SIGN | ATURE | TITLE | | (X6) DATE |
| 7 Y Je | less G. The | willing a deficiency whi | ch the inc | Homen is true to a | ding it is date | ////7 |

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Facility ID: TN5302

PRINTED: 07/20/201 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 01 - MAIN BUILDING 01 COMPLETED 44E445 B. WING 07/17/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIII CODE 700 WILLIAMS FERRY RD **BAPTIST HEALTH CARE CENTER** LENOIR CITY, TN 37771 SUMMARY STATEMENT OF DEFICIENCIES ID. PROVIDER'S PLAN OF CORRECTION (XS) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL) PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY K 000 INITIAL COMMENTS K 000 A life safety survey was conducted by the state of K291 Continued Tennessee Department of Health, Division of health licensure and regulation office of health a check box for annual 90 minute care facilities on 7/17/17. During this life safety survey, Baptist Health Care Center was not found testing. to be in substantial compliance with the requirements for participation in How the facility will monitor its Medicare/Medicaid at 42 CFR Subpart 483.70(a), corrective actions to ensure the Life safety from fire, and the related National Fire deficient practice is being corrected Protection Association (NFPA) standard 101 and will not recur. 2012 edition. The requirement at 42 CFR, Subpart 483.70(a) is The Maintenance Director or NOT MET as evidenced by: Administrator will report findings of K 291 NFPA 101 Emergency Lighting K 291 the Preventative Maintenance Log to SS≂F the monthly Quality Assurance **Emergency Lighting** Emergency lighting of at least 1-1/2-hour duration Performance Improvement Committee is provided automatically in accordance with 7.9. (members include: Committee 18.2.9.1, 19,2,9.1 Chairperson – Administrator: Director This STANDARD is not met as evidenced by: of Nursing; Medical Director; Dietary Based on observation and interview, the facility failed to maintain emergency lighting with battery Director, Pharmacy Representative, backup. This deficiency affected 8 of 8 smoke Social Services Director: Activities compartments. Director; Environmental Director/ Safety Representative; Infection NFPA 101, 19,7.6 Control Representative Staff NFPA 101, 7.9.3.1.1(3) Development Coordinator;

The finding includes:

Observation and interview with the maintenance director on 7/17/17 at 9:41 AM revealed the emergency lighting with battery backup was not being tested for 90 minutes annually.

The maintenance director was present when the

Date of Compliance: 8-17-17

suggestions and/or follow up as

Rehabilitation Director, and Medical

Records Director.) ongoing for further

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

needed.

| DEPAR | RTMENT OF HEALTH | AND HUMAN SERVICES | | į. | RINTED | 07/20/201 |
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| CENTE | RS FOR MEDICARE | & MEDICAID SERVICES | | | FORM | 1 APPROVEL |
| STATEMENT OF DEFICIENCIES (X1) PROVIDE | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | IPLE CONSTRUCTION IG 01 - MAIN BUILDING 01 | OMB NO. 0938-039 ⁷ (X3) DATE SURVEY COMPLETED | |
| | | 44E445 | B. WING_ | | | • |
| NAME OF | PROVIDER OR SUPPLIER | | · | STREET ADDRESS, CITY, STATE, ZIF CODE | 1 07 | /17/2017 |
| BAPTIS | T HEALTH CARE CEN | TER | | 700 WILLIAMS FERRY RD LENOIR CITY, TN 37771 | | |
| (X4) ID PREFIX TAG | ! (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO TO E APPROPRIEMCY) |) RE | (X5) COMPLETION OATE |
| K 291 | Continued From page deficiency was identified by the administrator 7/17/17. | ge 1 tified and was acknowledged during the exit conference on : | K 29 | How the corrective action(s) w | ill be | : : |
| K 324 SS=D | NFPA 101 Cooking Facilities | | | accomplished for those resident found to have been affected by deficient practice. | the | ; |
| | | | | The stove/griddle was secured to the wall on 7-19-17 to prevent over extension of the gas line. | | |
| : | | | | How the facility will identify of Residents having the potential affected by the same deficient practice. | her to be | |
| | | | | The Maintenance Director in-servine maintenance staff on 7/19/17 ensure they fully understand the preventative maintenance scheduland the components to what need be inspected such as ensuring stove/griddle secured to the wall a prevention of over extending the line. | to le s to | |
| · · · · · · · · · · · · · · · · · · · | Based on observatio failed to maintain the equipment. This defi compartments. | not met as evidenced by: n and interview, the facility commercial cooking ciency affected 1 of 8 smoke | | What measure will be put in pla or systemic changes made to en that the deficient practice will r recur. A preventative maintenance form | sure lot was | |
| . | NFPA 101, 19.7.6 | | | put in place on 7/19/17 to check a | II . | |

equipment and safety functions of the

PRINTED: 07/20/2017 FORM APPROVED OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION , | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIF A. BUILDING | (X3) DATE SURVEY COMPLETED | |
|--|---|---|----------------------------|--|--|
| | | 44E445 | B. WING | | 07/17/2017 |
| | PROVIDER OR SUPPLIER THEALTH CARE CEN | | | STREET ADDRESS, CITY, STATE, ZIF CODE 700 WILLIAMS FERRY RD LENOIR CITY, TN 37771 | 371772017 |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIM DEFICIENCY) | E COMPLETIO ATE DATE |
| K 324 | Continued From pa deficiency was iden by the administrate 7/17/17, NFPA 101 Cooking | ntified and was acknowledged or during the exit conference on | K 291 K 324 | dictary department. This will be completed monthly ongoing begin on 7/19/17 | ning |
| SS=D | Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 | | | How the facility will rounitor its corrective actions to ensure the deficient practice is being correct and will not recur. The Maintenance Director or Administrator will report findings the Preventative Maintenance Repto the monthly Quality Assurance Performance Improvement Comm (members include: Committee Chairperson – Administrator; Director; Pharmacy Representative Social Services Director; Activitie Director; Environmental Director/Safety Representative; Infection Control Representative/Staff Development Coordinator; Rehabilitation Director; and Medical Direct | of ort ittee ector tary e; s |
| | Based on observat failed to maintain the | s not met as evidenced by: ion and interview, the facility ie commercial cooking eficiency affected 1 of 8 smoke | | Records Director.) ongoing for fur suggestions and/or follow up as needed. Date of Compliance: 8-17-17 | ther ! |
| : | NFPA 101, 19.7.6 | | | : | · · · |

| CENTE | | AND HUMAN SERVICES & MEDICAID SERVICES | T | | FORM MB NO | 07/20/201 APPROVE 0938-039 |
|--|---|---|--|--|---------------|----------------------------------|
| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (DENTIFICATION NUMBER: | | 1 | LE CONSTRUCTION 6 01 - MAIN BUILDING 01 | (X3) DATE SURVEY COMPLETED | | |
| | | 44E445 | B. WING | | 07/ | 47 <i>1</i> 2042 |
| NAME OF | PROVIDER OR SUPPLIER | | , , | STREET ADDRESS, CITY, STATE, ZIP CODE | 1 077 | 17/2017 |
| BAPTIS | T HEALTH CARE CEN | TER | 7 | 700 WILLIAMS FERRY RD LENOIR CITY, TN 37771 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CURRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THIS APPROP DEFICIENCY) | BE | (X5) COMPLETION DATE |
| K 324 | Castley of Face | | | K 711: | | |
| 11 324 | : · · · · · · · · · · · · · · · · · · · | _ | K 324 | | | |
| | NFPA 54, 18.5.4.4.7 | | | How the corrective action(s) w | ill be | |
| | The finding include: | SI . | | accomplished for those residen | its | |
| | : | | | found to have been affected by | | |
| | Observation and int | terview with the maintenance | | deficient practice. | | |
| | director on 7/17/17 | at 10:24 AM revealed the | | · · · · · · · · · · · · · · · · · · · | | |
| | stove/griddle was o | n casters and not secure to | | Dietary staff was in-serviced on | | |
| | prevent overextens | ion of the flexible gas line. | | | | |
| | The maintenance d | irantan | | and when to use the hood suppre | | |
| | deficiency was idea | irector was present when the tiffed and was acknowledged to | | system by the Maintenance Direct | ctor | |
| | by the administrator | during the exit conference on | | on 7-18-17. | | |
| | 7/17/17, | during the exit contenence on : | | The Fire Plan was updated by the | 3 | |
| | | on and Relocation Plan | K 711 | Maintenance Director on 8/8/17 | to | |
| SS≍F | | on and relocation ran | KIII | include that the front nursing stat | | |
| | Evacuation and Rei | ocation Plan | | nurse is to dial 911 when fire alar | | |
| : | There is a written pi | an for the protection of all | | sounds as a back up to notifying | | |
| | patients and for their | r evacuation in the event of | | emergency services. | | |
| - | an emergency. | | | omergoney services. | | |
| | Employees are period | odically instructed and kept | | TT | | |
| | informed with their o | luties under the plan, and a | | How the facility will identify of | | |
| | copy of the plan is n | eadily available with telephone | | Residents having the potential | to be | |
| | basic response red | urity. The plan addresses the irred of staff per 18/19.7.2.1.2 | : | affected by the same deficient | | |
| | and provides for all | of the fire safety plan | | practice. | | |
| | components per 18/ | 19.2.2 | | | | |
| | 18.7.1.1 through 18. | 7.1.3, 18.7.2.1.2, 18.7.2.2, | | All residents have the potential to | be 🗄 | |
| | 18.7.2.3, 19.7.1.1 th | rough 19.7.1.3, 19.7.2.1.2, | | affected. All staff in all departme | nts | |
| | 19.7.2.2, 19.7.2.3 | | | will be in-serviced on the updated | | |
| | This STANDARD is | not met as evidenced by: | | Plan by 8-17-17 which includes f | | |
| | Based on observati | on, record review and | : | Time by 0-17-17 Willow the Miles ! | ioni : | |

compartments.

NFPA 96, 10.5,7

NFPA 101, 19.7.2.2(3)

This deficiency affected 8 of 8 smoke

interview, the facility falled to ensure required

documents and training were being maintained.

nursing station nurse noticying 911

hire staff will be in-serviced during their orientation period. Dietary staff

were in-serviced by the Maintenance

when fire alarm sounds as a back up to 1

notifying emergency services. All new

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| 1 | | E & MEDICAID SERVICES | | | OMB NO | 0. 0 <mark>938-0</mark> 39 |
|---|---|---|---------------------|--|---|----------------------------|
| STATEMENT OF DEFICIENCIES OF AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 | TIPLE CONSTRUCTION NG 01 - MAIN BUILDING 01 | (X3) DA | TE SURVEY MPLETED |
| | | 44E445 | 8. WING_ | , | 07 | //17/2017 |
| NAME OF | PROVIDER OR SUPPLIER | | ' | STREET ADDRESS, CITY, STATE, ZIF COD | | 71772011 |
| BAPTIS | T HEALTH CARE CEN | ITER | | 700 WILLIAMS FERRY RD | | |
| | | | | LENOIR CITY, TN 37771 | | |
| (X4) ID PREFIX TAG | ! (EACH DEFICIENC) | NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY) | OULD.BE | (X5) COMPLETION DATE |
| V 744 | Onelles of France | • | : | Director on 7-18-17 on how | and when | |
| N I I I | Continued From pa | ige 3 | Continued | 11: to use the hood suppression: | system. | |
| | The findings include | e: | | What measure will be put i | n place | <u> </u> |
| | . Observation record | d review and interview with the | : | or systemic changes made | n prace | |
| | , maintenance direct | or on 7/17/17 between 10:02 | : | that the deficient practice | will not | • |
| | AM and 10:15 AM a | revealed; | ! | recur. | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | |
| | 1. There was no b | packup 911 call to the fire | : | | | |
| | department, | | : | The Maintenance Director w | | : |
| | 2. One of two diet | ary staff interviewed was not | | monitor dictary staff knewled | lge on | |
| | components. | od suppression system and | | how and when to use the hoo | | 1 |
| | | | | suppression system mon hly | | - |
| | The maintenance d | irector was present when the | | utilizing a log to record response | | li |
| | deficiencies were id | lentified and was ne administrator during the exit | K 92 | any extra training on the syst | | |
| | conference on 7/17 | /17. | | was completed. This will be in on 8/9/17. The Maintenance | | |
| K 920 | NFPA 101 Electrica | l Equipment - Power Cords | | will ensure during fire drills t | bat staff | i |
| SS≈D | and Extens | | | are able to voice that the from | f nursing | |
| • | Electrical Equipmen | nt - Power Cords and | | station nurse will dial 911 in | | |
| | Extension Cords | • | • | to the fire alarm sounding and | | |
| | Power strips in a pa | tient care vicinity are only | | record of such along with any | | |
| | used for component | ts of movable electrical equipment | | additional documentation for | Iraining | |
| | (PCREE) assemble | s that have been assembled | | that is needed. This will be in | itiated | • |
| | by qualified personr | nel and meet the conditions of | | by8/17/17. | | |
| | 10.2.3.6. Power strips in the patient care vicinity | | | • | | |
| | may not be used for electronics), except | non-PCREE (e.g., personal | | How the facility will menito | | |
| : | electronics), except in long-term care resident rooms that do not use PCREE. Power strips for | | | corrective actions to ensure | | |
| | PCREE meet UL 13 | 63A or UL 60601-1. Power | | deficient practice is being co and will not recur. | rrected | |
| | | E in the patient care rooms meet UL 1363. In non-patient | | and will hot recur. | : | 1 |
| | care rooms, power s | | | The Maintenance Director or | | : |
| | standards. All powe | er strips are used with general. | | Administrator will report find | ings of | - |
| | | sion cords are not used as a | | the Hood Suppression Lcg an | | |
| | substitute for fixed v | инид от а structure. | | of the Fire Drills to the a onth | | |
| | | | | | · | |

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 01 - MAIN BUILDING 01 44E445 B. WING 07/17/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 700 WILLIAMS FERRY RD BAPTIST HEALTH CARE CENTER LENOIR CITY, TN 37771 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY Quality Assurance Performance K 711, Continued From page 3 K 711: Improvement Committee (members include: Committee Chairnerson -The findings include: Administrator; Director of Nursing; Medical Director; Dietary Director; Observation, record review and interview with the maintenance director on 7/17/17 between 10:02 Pharmacy Representative; Social AM and 10:15 AM revealed: Services Director; Activities Director; Environmental Director/ Safety There was no backup 911 call to the fire Representative; Infection Control department. Representative/Staff Development One of two dietary staff interviewed was not familiar with the hood suppression system and Coordinator; Rehabilitation Director; components. and Medical Records Director.) ongoing for further suggestions and/or The maintenance director was present when the follow up as needed. deficiencies were identified and was acknowledged by the administrator during the exit Date of Compliance: 3-17-17 conference on 7/17/17. K 920 NFPA 101 Electrical Equipment - Power Cords K920 K920: SS=D and Extens How the corrective action(s) will be Electrical Equipment - Power Cords and accomplished for those residents Extension Cords Power strips in a patient care vicinity are only found to have been affected by the used for components of movable deficient practice. patient-care-related electrical equipment (PCREE) assembles that have been assembled The multi-plug adaptors were by qualified personnel and meet the conditions of removed from Room 43 and 42 on 10.2.3.6. Power strips in the patient care vicinity 7/20/17 and replaced with regulatory may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident compliant equipment on 7/20/17. The rooms that do not use PCREE. Power strips for extension cord was removed from PCREE meet Ut. 1363A or Ut 60601-1. Power Room 41 on 7/20/17 and replaced strips for non-PCREE in the patient care rooms with regulatory compliant equipment (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL on 7/20/17. standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure.

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 01 - MAIN BUILDING 01 44E445 B. WING 07/17/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 700 WILLIAMS FERRY RD BAPTIST HEALTH CARE CENTER LENOIR CITY, TN 37771 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION 1D (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY How the facility will identify other K 920, Continued From page 4 K 920. Residents having the rotential to be Extension cords used temporarily are removed immediately upon completion of the purpose for affected by the same deficient which it was installed and meets the conditions of practice. 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 All residents have the potential to be (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 affected. A full facility assessment by This STANDARD is not met as evidenced by: the Maintenance Director was Based on observation and interview, the facility failed to ensure electrical system was maintained. conducted on 7/18/17 to ensure no This deficiency affected 1 of 8 smoke further multi-plug adaptors or compartments. extension cords were in use. NFPA 101, 19.7.6 What measure will be put in place NFPA 99, 10.2.4 or systemic changes made to ensure The findings include: that the deficient practice will not recur. Observation and interview with the maintenance director on 7/17/17 between11: 50 AM and 11:59 AM revealed: Weekly room checks were initiated on 7/18/17 to be performed by the 1. Room 43 the hospital bed was plugged into a maintenance department to ensure no multi-plug adapter. further issues with unapproved multi-2. Room 42 a multi-plug adapter in use in the plug adaptors or extension cords patient care area. ongoing, Only UL 1353A power Room 41 the oxygen concentrator was plugged into an extension cord in the patient care strips to be utilized if needed in the area. facility. The maintenance director was present when the deficiencies were identified and was acknowledged by the administrator during the exit: conference on 7/17/17.

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A, BUILDING 01 - MAIN BUILDING 01 44E445 B. WING 07/17/2017 NAME OF PROVIDER OF SUPPLIER STREET ADDRESS, CITY, STATE, 2'P CODE 700 WILLIAMS FERRY RD BAPTIST HEALTH CARE CENTER LENOIR CITY, TN 37771 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR USC IDENTIFYING INFORMATION) DATE CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY K 920, Continued From page 4 K 920. How the facility will monitor its corrective actions to ensure the Extension cords used temporarily are removed immediately upon completion of the purpose for deficient practice is being corrected which it was installed and meets the conditions of and will not recur. 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 The Maintenance Director or This STANDARD is not met as evidenced by: Based on observation and interview, the facility Administrator will report findings of failed to ensure electrical system was maintained. the Weekly Room Checks to the This deficiency affected 1 of 8 smoke monthly Quality Assurance compartments. Performance Improvement Committee NFPA 101, 19.7,6 (members include: Committee NFPA 99, 10.2.4 Chairperson - Administrator; Director of Nursing; Medical Director; Dietary The findings include: Director; Pharmacy Representative; Social Services Director; Activities Observation and interview with the maintenance director on 7/17/17 between 11: 50 AM and 11:59 Director; Environmental Director/ AM revealed; Safety Representative; Infection Control Representative/Staff 1. Room 43 the hospital bed was plugged into a Development Coordinator; multi-plug adapter. Room 42 a multi-plug adapter in use in the Rehabilitation Director, and Medical patient care area. Records Director.) ongoing for further Room 41 the oxygen concentrator was suggestions and/or follow up as plugged into an extension cord in the patient care needed. area. Date of Compliance: 8-17-17 The maintenance director was present when the deficiencies were identified and was acknowledged by the administrator during the exit; conference on 7/17/17.